



2005 Michigan Youth Horse Racing Program **PARTICIPANT INFORMATION**

"Bringing yesterday's tradition of horse racing back to our youth"

Name: _____
Last First MI

Address: _____
Street

City State ZIP

Phone (____) _____ Date of Birth: ____ / ____ / ____ Grade: ____
Month Day Year

Participants Age: _____ Equines Age: _____ Years Riding Equine: _____

Equines Name: _____

Breed of Equine: _____ Speed or Pleasure: _____

Events Participated In: _____

Awards Won: _____

Future Endeavors: _____

I have read, understand, and will abide by the 2005 Youth Horse Racing Rules and Regulations.

X _____
Signature of Participant Print Participants Name Month / Day / Year

Liability Release and Equine Liability Act:

The information provided on both pages of this form is true and is not intended to mislead. In the event that the information is discovered to be false or intentionally misleading, certification may be revoked, any purses or awards received may be revoked, and/or ineligibility for future participation in the Michigan Youth Horse Racing Program may be issued.

Except in the event of gross negligence on the part of the Michigan Youth Horse Racing Program or the administrators associated with the Michigan Youth Horse Racing Program, I shall bring no claims, demands, actions and causes of action, and/or litigation, against the Michigan Youth Horse Racing Program and the administrators for any economic or non economic losses due to bodily injury, death, and/or property damage sustained to the participant, the participants parents/legal guardian, and/or the participants equine in relation to the Michigan Youth Horse Racing Program while participating in the events of the Michigan Youth Horse Racing Program.

X _____ Signature of Participant	_____ Print Participants Name	_____/_____/_____ Month Day Year
X _____ Signature of Guardian	_____ Print Guardians Name	_____/_____/_____ Month Day Year
X _____ Signature of Witness	_____ Print Witnesses Name	_____/_____/_____ Month Day Year

Emergency Medical, Dental, or Surgical Treatment of a Minor:

I, _____, am the (mother) (father) (guardian) of _____, a minor who is participating in the Michigan Youth Horse Racing Program. I hereby consent to any medical, dental, or surgical treatment or procedure of an emergency nature that is necessary.

Insurance Company _____

Policy Number _____

Emergency Phone Numbers:

Number:	Person to Contact:
(____) _____	_____
(____) _____	_____
(____) _____	_____

I understand that should medical emergency treatment be required, the current insurance information listed above will be provided to the attending clinic or hospital to cover payment of incurred bills. Furthermore, I agree I will be financially responsible for treatment or procedure that is not covered by insurance. The Michigan Youth Horse Racing Program will have no financial responsibility for treatments or procedures.

X _____ Signature of Guardian	_____ Print Guardians Name	_____/_____/_____ Month Day Year
X _____ Signature of Witness	_____ Print Witnesses Name	_____/_____/_____ Month Day Year